Fourth Set of Questions and Answers on Extra Payment in Recognition of Successful Outpatient CHF Care -- Updated August 3, 2001

Q1: When the Extra Payment specification requires a "greater than one-day stay," do you have a formal definition of what a greater than one-day stay is?

A: The definition of a greater than one-day stay is the "from" date minus the "through" date. If the result is greater than one, then it would be a greater than one-day stay.

Q2: Do I have to report separately for each "H" number? Or can you combine H numbers?

A: You must report separately for each H number to qualify for the extra payment, and may not combine H numbers. Therefore, your denominators should be specific to an individual H and not a combination of enrollees from more than one H.

Q3: When can I begin submitting my report via the Health Plan Management System (HPMS)?

A: HPMS will be up and running for M+COs to submit their CHF extra payment activity reports no later than October 1, 2001, the first date that M+COs may report their numbers to CMS.

Q4: I have heard that CMS will provide updated information on enrollees in my plan with a CHF discharge diagnosis. These data would update the information that has been provided to us via the Monthly Membership Report (MMR). Is this true? When will this become available? How will I access it?

A: CMS has developed an approach to providing updated CHF discharge diagnoses at the individual enrollee level via the Health Plan Management System (HPMS). CMS has been providing "flags" on the MMR to reflect CHF discharge diagnoses that had been received by CMS as of 9/30/00. However, the information on HPMS will give each M+COs a more recent snapshot of those enrollees with a CHF discharge diagnosis that was submitted to CMS by the previous payment quarter. Around mid-August, M+COs will be able to log onto the HPMS and receive a listing of all HIC numbers for their H number who had a discharge diagnosis of CHF in the two years that are included in the population: 7/1/99-6/30/00 and 7/1/00-6/30/01 that have been received by CMS. These updates will be provided on a quarterly basis. In 2003, the quarterly updates will add a third year of CHF inpatient hospitalizations (between 7/1/01 and 6/30/02).

Q5: In earlier sets of Q's and A's you described the sampling approach for extra payment. However, I do not understand if I must oversample the first

denominator so that I get more than 400 in my second denominator so that I may sample the second denominator as well.

A: No. If in fact you have sampled on the first denominator and report on 400 in your sample, you will not be able to sample on the second denominator since it is a subset of the first denominator and by definition will be equal to or less than 400. You may not use sampling for fewer than 400 enrollees. Therefore, you should not need to oversample your first denominator since you will report on all those in the second denominator.

Q6: I understand CMS is planning an analysis of the CHF extra payment activity. Can you tell me what is included in that analysis, the timing of the analysis and what data will M+COs be expected to furnish for the analysis?

A: CMS is planning an analysis of the CHF extra payment activity beginning this fall and running through 2003. The analysis was designed to reflect the types of information requirements reflected in OPL 2000.129 and subsequent Questions and Answers. There are no new data reporting requirements. There are several objectives of this analysis including analyzing discrepancies between what M+COs report to CMS and the information reflected in CMS data sets, performing a medical record review, and synthesizing the two-page descriptions of disease management that M+COs will report to CMS. The medical record review will confirm the validity of the reported discharge diagnosis and two quality indicators to assure accuracy of payments. The timing on analyzing discrepancies and performing a medical record review would not occur until 2002, and likely after payments are made to M+COs. For further information, refer to section 7 entitled "auditing" of OPL 2000.129. Other information is contained in questions and answers # 10, 11, and 12 in the first set of Q's and A's posted on the CMS website in February at: http://www.hcfa.gov/medicare/congstqa.htm and in questions and answers 2 and 3 in the second set of Q's and A's posted on the CMS website in April at: http://www.hcfa.gov/medicare/chfaddqa.htm. Additional information on the CHF analysis may be obtained by contacting Mike Valle at Mvalle@cms.hhs.gov.

Q7: I see that there are inconsistencies in the third set of Q's and A's in response to questions 1 and 12 in determining the M+CO's payment in 2002, based on the year the hospitalization took place. In some cases the PIP-DCG factor is written greater than a PIP-DCG 8, PIP-DCG 8 or greater, or less than a PIP-DCG 7. Which of these is correct?

A: The correct answer is PIP-DCG 8 or greater. That is, for M+COs with a CHF hospitalization between 7/1/99 and 6/30/00 that also had a hospitalization occurring between 7/1/00-7/30/01 that was a PIP 8 or greater, the M+CO would receive the regular risk adjusted payment at the 10% phase-in level for the PIP 8 or greater. This would reflect a hospitalization between 7/1/00 and 6/30/01. In the case of a hospitalization in both years, the M+CO would received the regular

phased-in payment rather than the extra payment because the extra payment is less than what a M+CO would receive for a PIP 8 or greater, and CMS pays for the higher of the two payments.